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PLE01
Workplace reciprocity of emergency nurses: a qualitative study

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Emergency nurses work with other health care providers under uncertain conditions to provide care to patients with all kinds of illnesses and afflictions from all walks of life. Despite implications that they must work together to accomplish their tasks, there are few studies that explore the relationships among emergency department personnel. Furthermore, there are even fewer that focus on the way emergency nurses work together to provide care to their patients. The purpose of the study was to understand the lived experience of workplace reciprocity of emergency nurses through the use of a qualitative phenomenological method. Nurses with three or more years of current emergency nursing experience were recruited using a purposive technique to obtain a convenient sample. Each participant was interviewed. The data were analyzed and interpreted using Giorgi's Phenomenological Method. Findings from this study identified six essences: emergency department culture, balancing, technology, caring, bridging, and connection. These essences of the participants' experiences were synthesized. Workplace reciprocity between and among emergency department nurses is influenced by the emergency department culture, balancing, and technology on caring for patients and each other as seen in the bridging and connection for the purpose of creating and maintaining workplace relationships. This statement synthesized the meaning of workplace reciprocity among this sample of emergency nurses for this study. Paterson and Zderad's Humanistic Nursing Theory emerged as a way to reflect on the findings in a way that was meaningful to nursing. Implications for nursing practice and recommendations for future research are identified.

PLE02
Trauma nursing case management improves patient outcomes

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Background: The purpose of the study was to measure the effect of trauma case management (TCM) on patient outcomes, using practice-specific outcome variables such as in-hospital complication rates, length of stay, resource use and allied health service intervention rates. **Methods:** TCM was provided 7 days a week to all trauma patient admissions. Data from 754 patients were collected over 14 months. These data were compared with 777 matched patients from the previous 14 months. **Results:** TCM greatly improved time to allied health intervention ($P < 0.0001$). Results demonstrated a decrease in the occurrence of deep vein thrombosis ($P < 0.038$) and a trend towards decreased patient morbidity, unplanned admissions to the intensive care unit and operating suite. A reduced hospital stay LOS, particularly in the paediatric and 45–64 years age group was noted. Six thousand six hundred twenty-one fewer pathology tests were performed and the total number of bed days was 483 days less than predicted from the control group. **Conclusion:** The introduction of TCM improved the efficiency and effectiveness of trauma patient care in our institution. This initiative demonstrates that TCM results in improvements to quality of care of trauma patients.

PLE03
Bedside behaviors and their impact on patient safety

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It's easy to say "I am a safe ED nurse". I always check my five rights before administering a medication. I check the patient's identification before performing any test or procedure. I put the side rails of the stretcher up and the call bell within the patient's reach ... always. While these actions are critical to maintaining patient safety, we often forget that our behaviors at the bedside contribute to the culture of safety in the department. A lack of true teamwork, inability to provide constructive feedback, team members unwilling to hold each other accountable and fostering an environment where only the "weak" ask for help put our patients and ourselves in harm's way. This presentation will identify destructive bedside behaviors that are currently alive and well in emergency departments all across the globe. The teamwork concepts of "mutual support" and "situation awareness and monitoring" will be presented and discussed during the session. Tools and strategies to utilize these concepts in your own emergency department will be provided to participants.

☆ Publisher's Note: The abstracts printed were correct at the time of going to press. There may been subsequent changes in the programme that are not reflected.

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Conclusion: This study identified significant written and oral communication deficits. Inadequate communication resulted in extended ED length of stay and the provision of care that was not in keeping with resident wishes.

O4.2
The number of patients simultaneously present at the emergency department as an indicator of unsafe waiting times: a receiver operated curve-based evaluation

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Introduction: Emergency department (ED) crowding and prolonged waiting times have been associated with adverse consequences towards patient safety. **Aim:** To investigate whether the number of patients simultaneously present at the ED might be an indicator of unsafe waiting and at what threshold hospital-wide measures to improve patient outflow could be justified. **Methods:** Data were retrospectively collected during a 1-year period; all ED patients aged <16 years, and triaged as ESI-1 or ESI-2 were eligible for inclusion. The number of patients simultaneously present was used as occupancy rate. Waiting time was considered unsafe if it was longer than 10 min for ESI-1 patients, or longer than 30 min for ESI-2 patients. Differences in waiting time and occupancy between patients with safe and unsafe waiting times were analysed using Mann–Whitney U test. The ability of the occupancy rate to discriminate unsafe waiting times was analysed using a receiver operating characteristic curve. **Results:** Overall median waiting time was 5 min (IQR = 4–8) for ESI-1, and 12 min (IQR = 6–24) for ESI-2 patients. Unsafe waiting times occurred in 16.0% of ESI-1 patients (median waiting time = 17 min, IQR = 13–23), and in 18.9% of ESI-2 patients (median waiting time = 48 min, IQR = 37–68). The occupancy rate was a weak indicator for unsafe waiting times in ESI-1 patients (AUC = 0.625, 95% CI 0.537–0.713) but a fair indicator for unsafe waiting times in ESI-2 patients (AUC = 0.740, 95% CI 0.727–0.753) for which the threshold to predict unsafe waiting times with 90% sensitivity was 51 patients. **Conclusion:** The number of patients simultaneously present is a moderate indicator of unsafe waiting times. Future initiatives to improve safe waiting times should not focus solely on occupancy, rather the focus should expand towards other factors affecting waiting time.

O4.3
'That's not my name' a patient safety project to improve accurate identification of patients in a UK emergency department

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Introduction: The incorrect identification of patients was outlined as a global issue in healthcare. The UK College of Emergency Medicine has highlighted misidentification as a 'never event' that is particularly relevant to emergency departments. **Methods:** In this project process mapping was used to highlight the areas of the emergency pathway particularly prone to misidentification. Current identification practice and adherence to trust policy were audited and the emergency nursing team was asked to complete a safety attitudes questionnaire. Staff focus groups were formed to gain some deeper understanding of the issues. **Results:** Analysis of this qualitative and quantitative data highlighted the areas of risk and the key individuals needed to influence change. The 'That's not my name' initiative was launched to address these issues. Subsequent audit showed an increase in the use of wristbands and a repeat of the staff safety questionnaire demonstrated improved understanding of the 'never events' initiative and reduced confusion around trauma alias names. Thematic analysis of the focus group responses exposed more subtle causes of patient misidentification in our department. Experience of misidentification incidents was common amongst emergency department staff; areas of particular risk were at streaming/waiting area, assessment and resuscitation. **Conclusions:** There remains a culture of identifying patients by their condition or cubicle, and a reliance on the nurses to identify patients to other members of the team. By making staff aware of these risks the use of emergency patient wristbands has increased and understanding of the 'never events' initiative improved. Clarification of the use of trauma alias names has been broadly welcomed.

O5.1
A baseline analysis on knowledge, attitudes and practices of nurses in emergency care in a volatile environment: Bossaso General Hospital

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Bossaso General Hospital is located in Puntland, Somalia, an area affected by prolonged civil conflict, terrorism, clan fighting and piracy. Challenges faced in the study area include limited levels of basic and specialized education, cultural aspects and attitudes, gaps in human and financial resources, limited teaching aids and equipment, time constraints, language barriers, high turn-over of nurses and other medical staff, and an extremely volatile security situation. **Purpose:** To identify the gaps in delivering emergency medicine education in an unstable and resource-deprived environment in Somalia, with the aim of developing innovative methods of teaching. **Methods:** The method used will be a descriptive cross-sectional study, using data collection techniques such as focus group interviews, observation, key informant interviews and any available scholarly article review. **Results:** Preliminary research among health care staff at the hospital ($n = 20$) showed that 19% of the nurses felt that visiting nurses offer some knowledge on emergency care, while 38% of knowledge was gained from visiting doctors. Regarding knowledge of emergency medicine, 88.9% of the nurses felt that emergency medicine is basically first aid. Whereas 75% followed emergency medicine protocols, these were from a variety of reference books. **Conclusions:** Conclusions drawn suggest that the knowledge of emergency medicine is limited. Therefore, the development of field curricula, practical and theoretical training by visiting practitioners, provision of additional teaching aids, tools and equipment, integration of multiple disciplines in training, and financial resource mobilization would be beneficial in improving knowledge, attitudes and practices in emergency care.

O5.2
'Fit for future' – expanding the senior clinical workforce in emergency care. Lived experience of the health education Wessex trainee consultant practitioner development programme

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Consultant nurses are well established within the Emergency Department environment (Charters et al., 2005; Crouch et al., 2003; Fontaine et al., 2007) and similar roles are now being developed for